Arizona Medical Board

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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on August 9, 2006 and 8:00 a.m. on August 10, 2006, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

Executive Director's Report

Investigations Office Report

Timothy Miller, J.D., Executive Director recognized Staff's accomplishments in investigations and noted the Investigations Office has arrived at a plateau of having an average of only 400 open cases consistently. Only 73 of those cases are pre-2006 cases and by the end of the year the Staff's goal is to have only the 2006 cases remaining open. In the past six months, the agency was able to attain the goal of completing investigations within 180 days.

Monitoring Office Report

Timothy Miller, J.D., Executive Director recognized the success of the Physician's Health Program. There were 30 physicians who self reported since beginning of the year 2006. A committee similar to the Staff Investigational Committee (SIRC) has been formed to review the reports of evaluations and treatment centers prior to the case going to the Staff Investigational Review Committee (SIRC). The new committee is called the Evaluation Review Committee (ERC).

Information Dissemination Office Report

Timothy Miller, J.D., Executive Director said the Public Information Dissemination Office is currently working towards making the Arizona Medical Board Directories available on line. Upon payment for a directory, a customer may be given an individual user name and password to enable them to download the Directory.

Licensing Office Report

Timothy Miller, J.D., Executive Director recognized the Licensing Office for their accomplishment in efficiently processing applications. The Licensing Office received 284 applications for the months of May and June and during that same time approved 273 new licenses. The Licensing Office maintained a 31 day turn-around for processing routine applications and a 45 day process period for applications that required an investigation. The Licensing Office was able to accomplish all those things while still issuing Locum Tenens Registrations, Post-Graduate Training Registrations, renewal applications, dispensing certificates, dispensing renewals and address changes.

Legal Advisor Report

Christine Cassetta, Board Legal Counsel provided the Board a Quarterly Report outlining the duties she performed last quarter.

Ms. Cassetta also provided a memo to the Board outlining the 2006 statutory amendments to the Medical Practice Act and other laws related to the practice of medicine that will become effective September 21, 2006.

Litigator Report

Dean Brekke, Assistant Attorney General said the Board's decision imposing discipline on Dr. Lior Kahane was appealed to the Arizona Court of Appeals. The Court of Appeals upheld the discipline imposed by the Board and the majority of the factual findings and conclusions of law. In

three minor instances the Court determined there was not sufficient evidence of wrong-doing to support the Board's Finding of Fact. Mr. Brekke asked the Board to amend the prior Findings of Fact, Conclusions of Law and Order in the following manner:
1. Delete paragraphs 176-178.
2. Delete paragraphs 518-519 and 523-529. Delete the words "in addition" in paragraph 520 and "initially" in paragraph 522.
3. Delete paragraphs 475-484.

MOTION: William R. Martin, III, M.D. moved to amend the Board's decision in accord with the decision of The Court of Appeals As outlined by Mr. Brekke.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Approval of Office Based Surgery Rules

William R. Martin, III, M.D. thanked the Staff for their help to move the drafted Office Based Surgery Rules forward. Specifically, Dr. Martin thanked Ram R. Krishna, M.D., Douglas D. Lee, M.D., Timothy J. Miller, J.D., Christine Cassetta, Board Legal Counsel and Lisa McGrane, Investigational Review Manager. Dr. Martin said at this point the Committee is awaiting public comment and input from any other boards that may want to contribute.

MOTION: William R. Martin, III, M.D. moved to adopt the Draft Office Based Surgery Rules.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Consideration of a Three Day October 2006 Board Meeting

The Board considered a three day meeting in October 2006 to help ease the backlog of completed cases awaiting a formal interview. Sharon B. Megdal, Ph.D. suggested the Board take care of Other Business Agenda matters during a teleconference. William R. Martin, III, M.D. said a three day meeting brings a hardship for physicians in private practice and that it would better for him to meet on a Saturday for the third day. Paul M. Petelin, Sr., M.D. said he would rather do two day meeting that was extended in length than to do a three day meeting. Robert P. Goldfarb, M.D. suggested the lead Board member be limited to 15 minutes of questioning to begin with, and then allow time at the end of the interview for additional questioning if necessary. Christine Cassetta, Board Legal Counsel suggested the Board Members, when preparing for cases, prepare more pointed questions to establish the standard of care and deviations more quickly.

The following Board Members said they would be available for a three day Board Meeting in October:
Dona Pardo, Ph.D., R.N.
Paul M. Petelin, Sr., M.D.
William R. Martin, III, M.D.
Ram R. Krishna, M.D.

The following Board Member said they would not be available for a three day Board Meeting in October:
Patricia R.J. Griffen
Lorraine Mackstaller, M.D.

The following Board Members were not present:
Tim B. Hunter, M.D.
Becky Jordan
Douglas D. Lee, M.D.

Sharon B. Megdal, Ph.D. said she did not yet know her schedule for October. Dr. Goldfarb suggested the Board Meet for a two day meeting in October and a one day Meeting in November. Dr. Goldfarb decided to vote on this matter at a later date.

Physician Health Program Request for Proposal (RFP)

The Board held an Executive Session to discuss or consider records exempt by law from public inspection, including the receipt and discussion of information or testimony that is specifically required to be maintained as confidential by state or federal law. A.R.S. §38-431.03(A)(2).

Instruct Executive Director on Physician Health Program RFP

The Board went into Executive Session at 5:58 p.m.
The Board returned from Executive Session at 6:25 p.m.

MOTION: Patrick N. Connell, M.D. moved to accept the Physician Health Program Request for Proposal.
SECONDED: William R. Martin, III, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

Approval of Minutes

Dona Pardo, Ph.D., R.N. provided staff with grammatical and typographical changes. Christine Cassetta, Board Legal Counsel asked the Board to amend the draft Minutes for case MD-04-0625B where the Board issued a Letter of Reprimand to H. Villar-Valdez, M.D. for failure to recognize discordance between the pre and post operative mammogram. Ms. Cassetta said the minutes reflect the Board found Dr. Villar-Valdez in fact did recognize the discordance between the mammograms. Ms. Cassetta said the discussion reflected the Board issued a Letter of Reprimand for failure to perform an adequate biopsy and not aggressively pursuing a repeat biopsy.

MOTION: Patrick N. Connell, M.D. moved to approve the June 7-8, 2006 Regular Session Minutes, including Executive Session Minutes, the June 8, 2006 Summary Action Meeting Minutes, and the July 19, 2006 RFP Teleconference Meeting Minutes, including Executive Session Minutes with amendments.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0376A	D.P.	CAROL D. HAYES, M.D.	20821	Advisory Letter for writing post-dated narcotic prescriptions.
2.	MD-05-0791A	AMB	GEORGE M. BERNSTEIN, M.D.	30794	Advisory Letter for failure to provide steroids in a COPD exacerbation.
3.	MD-05-0963A	M.W.	JOSEPH C. LINDSTROM, M.D.	17253	Invite the physician for a Formal Interview.

Paul M. Petelin, Sr., M.D. noted that, in this case, all of the patient's complaints generated from right sided pain and yet Joseph Lindstrom, M.D. removed the patient's left ovary.

Ingrid Haas, M.D., Medical Consultant said Dr. Lindstrom's operative note showed no indication for performing surgery on the patient's left ovary. Dr. Haas said she was not able to explain Dr. Lindstrom's thought process in this case by review of his medical records alone and that post-surgery the patient's pain was not resolved. Dr. Haas said she found it aggravating that Dr. Lindstrom wrote an addendum to his operative note after the Board began investigation of this case and after Dr. Lindstrom conceded there was no indication in his operative report for removal of the patient's left ovary.

Dona Pardo, Ph.D., R.N. noted the ovary Dr. Lindstrom did remove was normal.

MOTION: Ram R. Krishna, M.D. moved to invite the physician for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

William R. Martin, III, M.D. said he questioned the process of when the Medical Consultant requests further investigation and the Staff Investigational Review Committee (SIRC) recommends an Advisory Letter, when it appears should have been a Formal Interview. Robert P. Goldfarb, M.D. said he believed the process worked well because SIRC does not know how the Board is going to feel about each case, and most of the time SIRC makes a correct assumption on the avenue the Board will take. Dr. Goldfarb said it is the Board's job to review each and every case and determine if there are any items under the Advisory Letter section that they would like to hear as a Formal Interview. Paul M. Petelin, Sr., M.D. said all Board Members are responsible to review all Advisory Letters and that he thought the system worked fairly well.

Dr. Martin said he believed the Staff is extremely diligent in their investigation of the cases, he just wondered if the process could be improved. Becky Jordan said it is more efficient to have cases scheduled for Advisory Letters and then, if needed, referred to Formal Interview rather than to schedule as a Formal Interview, and decide the case warrants an Advisory Letter after a lengthy Formal Interview discussion.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0834A	AMB	RORY N. MINCK, M.D.	11912	Offer a Consent Agreement for a Letter of Reprimand for failing to personally and timely attend to a patient who was severely ill. If the physician declines, invite for a Formal Interview.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board and said Rory Minck, M.D. is currently located in Texas and is not practicing in Arizona. Dr. Haas said in this case Dr. Minck ordered and scheduled a surgical procedure without discussing the surgery with the patient and before the he even met the patient. Dr. Minck did not evaluate the patient himself before initiating care through the nursing staff.

Douglas D. Lee, M.D. said he was bothered by this case but did not know if any additional information could be gleaned by inviting the physician in for a Formal Interview. Dr. Lee said he did not believe the case rose to a level of discipline because the patient's outcome may not have been different. Patrick N. Connell, M.D. said the standard of care is the issue in this case, not the eventual outcome. Dr. Connell said the standard of care was for the physician to physically evaluate the critically ill patient.

MOTION: Ram R. Krishna, M.D. moved to accept the Advisory Letter for failure to personally and timely attend to a patient who was severely ill.
SECONDED: Paul M. Petelin, Sr., M.D.

Patrick N. Connell, M.D. spoke against the motion stating, although he was not confident a Formal Interview would bring out further information about the case, he did not believe an Advisory Letter was appropriate.

Paul M. Petelin, Sr., M.D. noted the physician currently practices in Texas. William R. Martin, III, M.D. thought it would be difficult to bring the physician in for a Formal Interview.

Ram R. Krishna, M.D. and the seconder withdrew the motion.

MOTION: William R. Martin, III, M.D. moved Offer a Consent Agreement for a Letter of Reprimand for failing to personally and timely attend to a patient who was severely ill. If the physician declines, invite for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0075A	N.W.	HENRY R. MORA, M.D.	26554	Advisory Letter for post-dating prescriptions.
6.	MD-05-0613A	D.T.	TERRY A. HUFF, M.D.	20570	Advisory Letter for inadequate medical records pertaining to informed consent regarding potential complications and the treatment options available.

Patient DT was present and spoke during the call to the public stating Dr. Huff has other disgruntled patients with whom she has spoken who also had not received adequate care from Dr. Huff. DT asked the Board to protect the public based on, not only the inappropriate care she received in her case, but also the inappropriate care other patients had received.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-1112A	N.J.	MARK H. WILSON, M.D.	13278	Advisory Letter for inadequate medical records and for prescribing a medication to which the patient was allergic.
8.	MD-06-0081A	T.B.	DANIEL T. FANG, M.D.	30861	Continue the case for additional information and invite the physician for a Formal Interview.

Daniel Fang, M.D. was present and spoke during the call to the public. Dr. Fang said, in retrospect with the knowledge of the infection in this patient, antibiotic treatment was not warranted as this type of infection tends to stabilize without treatment.

Paul M. Petelin, Sr., M.D. requested Staff to obtain additional information in this case including Dr. Fang's indications for performing bariatric surgery on the patient and also if, in case of the micro bacteria, the people involved in the care had to be treated for tuberculosis.

MOTION: Paul M. Petelin, Sr., M.D. moved to continue the case to obtain additional information and invite the physician for a Formal Interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-05-1023A	AMB	JONATHAN C. LOWRY, M.D.	22392	Advisory Letter for failure to send tissue samples to pathology.
10.	MD-05-0828A	AMB	PHILIP A. BAKER, M.D.	31466	Invite the physician for a Formal Interview.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. The Board was notified of a malpractice case alleging Philip Baker, M.D. failed to diagnose and treat pneumonia resulting in the death of a patient. It was alleged Dr. Baker did not perform a thorough evaluation for a patient with a fever and an elevated white blood count. Dr. Sems said it was mitigating that the patient did not complain of any pulmonary symptoms.

Patrick N. Connell, M.D. said he felt sufficient concern in this case and would like to invite the physician for a Formal Interview.

MOTION: Lorraine Mackstaller, M.D. moved to invite the physician for Formal interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-05-1069A	AMB	RAJIV KWATRA, M.D.	25383	Advisory Letter for inadequate documentation.
12.	MD-05-0428B	AMB	JOHN R. TESSER, M.D.	11285	Invite the physician for a Formal Interview.

William R. Martin, III, M.D. recused himself from this case.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. Dr. Sems said the patient in this case was mostly seen by a physician assistant whose notes were cosigned in part by Dr. Tesser. Dr. Sems said the notes showed the patient had 2+ pitting edema. Dr. Sems found the patient's clinical picture suggested nephrotic syndrome. Dr. Sems said there was no movement towards evaluation of the patient's symptoms and the physician assistant thought the pitting edema was a result of arthritis. Dr. Sems said Dr. Tesser may have missed the patient's diagnosis in this case, but that it was most likely Dr. Tesser did not adequately supervise the physician assistant and realize his need to asses the patient. Dr. Sems said it is mitigating that Dr. Tesser said he has since changed his practice and now supervises physician assistants more carefully.

MOTION: Robert P. Goldfarb, M.D. move to invite the physician for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

Ram R. Krishna, M.D. noted in general it seemed physicians do not seem to be aware of their obligations in supervising physician assistants. Robert P. Goldfarb, M.D. noted the Board recently saw several cases where physician assistants are not adequately supervised and asked Staff to look into this issue. Ms. Cassetta noted the issue has also come up at meetings of the Arizona Regulatory Board of Physician Assistants and the issue is being looked into and worked on.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-05-0603B	AMB	KURT F. DICKSON, M.D.	25409	Invite the physician in for a Formal Interview.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. Dr. Sems said the Board received notification of a medical malpractice settlement alleging Kurt Dickson, M.D. failed to perform an adequate evaluation of a patient leading to a delay of diagnosis of infectious process resulting in patient death. Dr. Sems said the investigation revealed Dr. Dickson fell below the standard of care by discharging the patient with joint pain and hematuria without investigating the patient's renal status.

Robert P. Goldfarb, M.D. said he found this case concerning because Dr. Dickson never saw the patient, only the physician assistant did. Dr. Goldfarb said that if Dr. Dickson had seen the patient he would have recognized the patient needed a further evaluation.

MOTION: Paul M. Petelin, Sr., M.D. moved to invite the physician in for a Formal Interview.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-05-1156A	E.G.	ALVIN E. GOLDANSKY, M.D.	17891	Advisory Letter for failure to adequately evaluate shortness of breath in a patient with a history of cancer.

Becky Jordan noted the patient in this case had valid continuing complaints and asked if the physician members felt there was more to this case. Lorraine Mackstaller, M.D. noted the physician diagnosed asthma as a result of a chronic cough work up. Dr. Mackstaller noted the patient had symptoms of lung cancer for six weeks before diagnosis of lung cancer was made. She noted that based on Dr. Goldansky's care in this case an advisory letter was appropriate.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to adequately evaluate shortness of breath in a patient with a history of cancer.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-05-0475A	AMB	CHRISTOPHER C.R. HINSON, M.D.	17419	Advisory Letter for failure to document refusal of a lumbar puncture.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Dr. Huber said it was alleged Christopher Hinson, M.D. failed to maintain adequate medical records for a patient and failed to diagnose a subarachnoid hemorrhage. The investigation revealed Dr. Hinson deviated from the standard of care by failing to perform a lumbar puncture for the patient prior to discharge, when the head CT was reported as negative.

Robert P. Goldfarb, M.D. said, although Dr. Hinson claimed the patient refused a lumbar puncture, there was no evidence in the nursing notes to support that statement. Victoria Kamm, Senior Medical Investigator said the patient presented to another hospital with the same scenario and refused a lumbar puncture at that location as well. This may indicate the patient refused the same procedure from Dr. Hinson.

Patrick N. Connell, M.D. said in Dr. Hinson's response he claimed he always does a lumbar puncture for such presentations and that he did claim he recorded the refusal, but the hospital lost part of the record. Dr. Connell said he believed the Board would not be able to obtain any additional information from a Formal Interview, and that inviting a physician in for such would only be an assessment of the physician's credibility.

MOTION: Ram R. Krishna, M.D. moved to accept the Advisory Letter for failure to document refusal of a lumbar puncture.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Patricia R.J. Griffen moved to issue an Advisory Letter for items 1, 2, 5, 6, 7, 9, and 11.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0455A	P.M.	MICHAEL J. CONWAY,M.D.	6878	Uphold Executive Director's Dismissal.

The complainant, PM was present and spoke during the call to the public. PM said she clearly stated she did not want any students present during her surgery. However, PM said Michael Conway, M.D. assured her he would respect her request, but then lied to her by having a student present during her operation.

Tina Geiser, Assistant Manager, Office of Investigations summarized the case for the Board. Ms. Geiser said Dr. Conway said for the first two procedures he was never informed of patient PM's requests. However, Dr. Conway learned of PM's request on the morning of the third procedure and at that time he attempted to comply with her requests.

Sharon B. Megdal, Ph.D. noted this may have been as simple as a communication issue in this case, but she still found it concerning. Robert P. Goldfarb, M.D. said that, even if the allegations in this case were sustained, the allegations did not fall under any category of the Medical Practice Act and therefore the Board did not have jurisdiction over this matter.

Ram R. Krishna, M.D. thought this was merely a matter of communication. William R. Martin, III, M.D. there was no statute the Board could apply in this case, despite the sympathy they felt for PM and her situation.

MOTION: Ram R. Krishna, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Becky Jordan
VOTE: 9-yay, 0-nay, 2-abstain, 0-recuse, 1-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0200A	AMB	ROBERT S. BAKER, M.D.	31745	Accept Proposed Consent Agreement for Surrender of Active License.
2.	MD-05-0381A	AMB	FRANCIS K. TINDALL, M.D.	14589	Accept Proposed Consent Agreement for a Letter of Reprimand for performing lateral debridement surgery instead of medial debridement surgery.
3.	MD-06-0091A	AMB	RICHARD P. GREENBERG, M.D.	13656	Accept Proposed Consent Agreement for Practice Restriction from performing any type of surgery until he receives permission from the Board to do so.

Robert P. Goldfarb, M.D. said he knew Dr. Greenberg but it would not affect his ability to adjudicate the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0855A	AMB	SHAWN D. BARRONG, M.D.	23832	Accept Proposed Consent Agreement for a Letter of Reprimand for failure to recognize a severed ureter in a timely manner resulting in the removal of a patient's kidney.
5.	MD-05-1094A	AMB	ROBERT M. OSIPOV, M.D.	72895	Accept Proposed Consent Agreement for a Letter of Reprimand for committing a misdemeanor involving moral turpitude.
6.	MD-05-0280A	AMB	JAMES N. YARUSSO, M.D.	31732	Accept Proposed Consent Agreement for a Letter of Reprimand for knowingly making a false statement to the Board.
7.	MD-06-0518A	AMB	MARCO CELAYA, M.D.	77732	Accept Proposed Consent Agreement for Surrender of Residency Permit.
8.	MD-05-0975A	AMB	LEE S. YOSOWITZ, M.D.	12610	Accept Proposed Consent Agreement for a Letter of Reprimand for failure to evaluate and treat pre-eclamptic symptoms resulting in maternal and fetal death.
9.	MD-05-0655A	M.L.	DONALD R. SCHIEVE	18602	Accept Proposed Consent Agreement for a Letter of Reprimand for failure to perform an adequate autopsy and failure to maintain adequate records.

MOTION: Douglas D. Lee, M.D. moved to accept the Proposed Consent Agreement for items 1-9.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Patrick N. Connell, M.D. and Tim B. Hunter, M.D.

VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-04-0912A	AMB	MAHDI S. AL-BASSAM, M.D	21073	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to timely diagnose a known complication of an abdominal aortic stent placement resulting in patient death.
11.	MD-05-0576A	AMB	ROBERT J. ALLEN, M.D.	15874	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to refer a patient for appropriate cardiac evaluation and 1 year Probation to include 20 hours of CME in electrocardiograph interpretation.
12.	MD-05-0514A	AMB	PAUL SAIZ, M.D.	25767	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing a surgery at a site not originally planned and that did not address the patient's problem, requiring a second surgery.

Douglas D. Lee, M.D. and William R. Martin, III, M.D. recused themselves from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-04-0625B	AMB	F. HUGO VILLAR-VALDES, M.D.	9674	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for performing an inadequate biopsy and for failing to aggressively pursue a repeat biopsy when he recognized the biopsy was inadequate.
14.	MD-04-0827A MD-05-0021A MD-05-0484A MD-05-1089A	S.R. AMB K.B. A.D.	MICHAEL CHASIN, M.D.	8082	Accept the Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for inappropriately interacting with his patients, including engaging in conversations of a sexual nature with patients. Three year Probation requiring the physician to submit to a psychologist for a minimum of 12 months, shall instruct psychologist to submit quarterly reports to the Board regarding his care, shall comply with psychologist's recommendations for continuing care, as amended.

Paul Giancola, counsel for Michael Chasin, M.D. was present and spoke during the call to the public requesting modification to the Findings of Fact in the Order against Dr. Chasin.

Patient K.B. was present and spoke during the call to the public. KB said Dr. Chasin massaged her husband's prostate as treatment for prostate cancer and that she said Dr. Chasin's inappropriate behavior showed he used his medical license for his own sexual gratification.

Christine Cassetta, Board Legal Counsel said most of the modifications Dr. Chasin requested dealt with the wording in the Order, but did not change the meaning of the findings. Ms. Cassetta said Dr. Chasin admitted his inappropriate conduct and only disagreed with some of the wording in the patient's complaints. Robert P. Goldfarb, M.D. said he did not want the Board's Order on the website to be a salacious reading. Dr. Goldfarb clarified he did not want the Board Order to go into great detail about the inappropriate misconduct, but yet he also did not want the meaning of the findings to be altered.

The Board went through each one of the amendments proposed by Mr. Giancola and discussed which amendments they would accept.

MOTION: Lorraine Mackstaller, M.D. moved to accept the Accept the Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for inappropriately interacting with his patients, including engaging in conversations of a sexual nature with patients. Probation for 3 years and shall submit to a psychologist for a minimum of 12 months, shall instruct psychologist to submit quarterly reports to the Board regarding his care, shall comply with psychologist's recommendations for continuing care, as amended.
SECONDED: Ram R. Krishna, M. D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-04-1545A	AMB	FRANK IORIO, M.D.	12233	Accept the Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for Failure to do a needle biopsy prior to performing thyroid surgery and failure to recognize a laryngeal nerve injury post-surgery.

MOTION: Sharon B. Megdal, Ph.D. moved accept the Findings of Fact, Conclusions of Law and Order for items 10-13 and 15.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-05-0175A	AMB	M. AZAM KHAN, M.D.	9994	Invite the physician for a Formal Interview.

M. Azam Khan, M.D. was present with counsel, Ed Hendricks, Sr. and both spoke during the call to the public.

Mr. Hendricks said the physician on shift with Dr. Khan at the time the events in this case occurred admitted he was not directly in communication with Dr. Khan, except for through a resident assisting in the case. Mr. Hendricks stated the resident admitted he did not specifically suggest to Dr. Khan that he check the patient.

Dr. Khan said he was told by Board Staff that he was in compliance with his Board Order prior to receiving notice of a referral to Formal Hearing. Dr. Khan said he has taken the Board's concerns seriously and has made a great effort to improve his practice.

MOTION: Douglas D. Lee, M.D. moved to refer the case to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.

Sharon B. Megdal, Ph.D. said she believed this case could be handled at a Formal Interview and it was not necessary to refer to Formal Hearing. William Wolf, M.D., Medical Consultant told the Board that the testimony of the other physician in this matter was continually evolving over time and was not consistent.

The Board noted Dr. Khan's prior Board history was significantly aggravating, but agreed that this case may not rise to the level of revocation. Dr. Lee withdrew his motion and the seconder agreed.

MOTION: Sharon B. Megdal, Ph.D. moved to invite the physician for Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-06-L020A	AMB	STANLEY S. RACZ, M.D.	12158	Uphold the ED Denial of License

Stanley Racz, M.D. was present and spoke during the call to the public. Dr. Racz said he voluntarily submitted to inpatient treatment and was discharged early by Sierra Tucson, against his request. Dr. Racz said he has remained seizure free for two years and six months and that he was now mentally and physically capable to practice medicine.

Kathleen Muller, Monitoring Office Manager summarized the case for the Board stating that on May 24, 2003 Dr. Racz entered Sierra Tucson for treatment. Ms. Muller said Sierra Tucson reported Dr. Racz experienced Benzodiazepine withdrawal, was suffering from cognitive difficulties and was therefore unfit to practice medicine. Ms. Muller said Dr. Racz subsequently accepted a Consent Agreement for Surrender of License. Ms. Muller said Dr. Racz re-applied for an Arizona license earlier this year, but provided no convincing proof that he met the criteria for Board's monitoring program for the following reasons:

1. There was no convincing proof to show a reasonable period of sobriety.
2. There was no adequate proof Dr. Racz completed a Board approved inpatient treatment facility for his chemical dependency.
3. There was no adequate proof Dr. Racz's neurological deficits raised by Sierra Tucson had been significantly addressed.

MOTION: Patrick N. Connell, M.D. move to uphold the ED Denial of License
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Tim B. Hunter, M.D., Becky Jordan, William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-04-L104A	AMB	MICHAEL R. JOHNSON, M.D.	N/A	Uphold ED Denial of License

Michael Johnson, M.D. was present and spoke during the call to the public. Dr. Johnson said he has been monitored by Michel Sucher, M.D. who stated he was at a place in his recovery where he could request a Probationary license to be granted by the Board.

Chris Banys, Monitoring Office Assistant Manager summarized the case for the Board. Ms. Banys said in 1999 Dr. Johnson's employer reported him to the Indiana State Board for due to bizarre outbursts while dictating transcription, dropping intraocular lenses and talking to himself during surgery. As a result, the Indiana State Board ordered Dr. Johnson to undergo a urine drug screen and obtain a psychiatric evaluation. During his treatment the treatment center reported bizarre behavior. Ms. Banys said, upon discharge, Dr. Johnson was told he was not psychologically fit to practice medicine. Dr. Johnson also submitted for a sexual compulsivity assessment after an attempt to kiss a female patient while in treatment. The assessment revealed Dr. Johnson's compulsions were driven by his delusional thought content rather than sexual addiction. Dr. Johnson was also treated for alcohol dependence. Ms. Banys said Dr. Johnson has since relocated to Arizona and has been privately monitored by an outside entity in order to remain in compliance with his Indiana state Board Order of Probation.

Patrick N. Connell, M.D. said he believed Dr. Johnson had significant issues that had not all been addressed or remediated.

MOTION: Patrick N. Connell, M.D. move to uphold the Executive Director's denial of license.
SECONDED: Patricia R.J. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were absent: Tim B. Hunter, M.D., Becky Jordan, William R. Martin, III, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-06-L012A	AMB	KAREN E. CROCKETT, M.D.	N/A	Order the physician/applicant to undergo a Physician Assessment and Clinical Evaluation (PACE).

Karen Crockett, M.D. was present and spoke during the call to the public. Dr. Crockett explained she filled out her application in all honesty and said she never received information in writing that she had been placed on Probation during her residency and therefore did not feel she had answered the application questions inappropriately.

Marlene Young, summarized case for the Board and stated Dr. Crockett submitted her application for an Arizona medical license and she did not disclose an academic Probation for unsatisfactory performance during her third year residency.

MOTION: Douglas D. Lee, M.D. moved to uphold the ED denial of license.
SECONDED: Patrick N. Connell, M.D.

Patrick N. Connell, M.D. seconded the motion for discussion and spoke against the motion stating he felt this was a serious action for a physician just out of residency. Robert P. Goldfarb, M.D. noted the investigation indicated Dr. Crockett had severe competency issues during her training as it took her eight years to complete her medical education. Dr. Goldfarb also noted Dr. Crockett was not thought of very highly by her residency supervisors. Sharon B. Megdal, Ph.D. said she found this case to be an issue of competence more than whether or not Dr. Crockett answered her application question incorrectly.

Lorraine Mackstaller, M.D. noted there were family illnesses and a death of a family member that Dr. Crockett said caused her to have difficulties during her training. Paul M. Petelin, Sr., M.D. asked if the Board could rehabilitate the physician without having to grant an Arizona license first. Christine Cassetta, Board Legal Counsel advised the Board that they could order Dr. Crockett to undergo an evaluation, without first issuing an Arizona license.

Douglas D. Lee, M.D. withdrew the motion and the seconder agreed.

MOTION: Paul M. Petelin, Sr., M.D. moved issue an Order to undergo Physician Assessment and Clinical Evaluation (PACE).
SECONDED: Douglas D. Lee, M.D.
VOTE: 8-yay, 0-nay, 1-abstain, 0-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-05-0257A MD-05-0275A	MM C.D.	JUSTIN F. WEISS, M.D.	9418	Rescind Referral to Formal Hearing and Dismiss.

Robert P. Goldfarb, M.D. recused himself from the case.

Dean Brekke, Assistant Attorney General summarized the case. Mr. Brekke said Dr. Weiss filed bankruptcy and, because his medical records were considered to be an asset according to Federal law, he turned the medical records over to the trustee. Mr. Brekke said, unknown to Dr. Weiss, the trustee abandoned the medical records and they were later found in a dumpster. Mr. Brekke said this case shows a conflict between Federal law and State law and that Federal law trumps State law. Mr. Brekke said he did not believe the Board had the authority to discipline Dr. Weiss for failing to maintain medical records.

MOTION: Lorraine Mackstaller, M.D. moved to Rescind Referral to Formal Hearing and Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-0151A	AMB	JERI B. HASSMAN, M.D.	16132	Accept the Motion for Rehearing or Review for the sole purpose of editing the Order by inserting "intra-articular" as indicated in Mr. Brekke's motion.

Sharon B. Megdal, Ph.D. recused herself from the case.

Mr. Brekke informed the Board that Dr. Hassman's motion for Rehearing or Review objected to the Board's findings and Mr. Brekke said Dr. Hassman was requesting the Board reconsider the Findings of Fact, and Conclusions of Law to correct what she viewed as inaccuracies in the record. Mr. Brekke said Dr. Hassman was not asking for reconsideration of the Order. Mr. Brekke and Ms. Cassetta asked the Board to grant the Motion solely for the basis of reviewing Paragraph 19 and adding "intra-articular" in lines 17 and 20 as indicated in Mr. Brekke's motion and to deny the remainder of Dr. Hassman's motion.

MOTION: Patrick N. Connell, M.D. moved to accept the motion for Rehearing or Review for the sole purpose of editing the Order by inserting "intra-articular" as indicated in Mr. Brekke's motion.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 1-recuse, 3-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
22.	MD-05-0351A	J.B.	JASON M. BELLAK, M.D.	29914	Accept the Executive Director's Referral to Formal Hearing.

Jason Bellak, M.D. was present with counsel Ms. Lisa Davis and both spoke during the call to the public. Ms. Davis said the Board's own medical consultant, David Greenberg, M.D., recommended the standard Physician Health Program monitoring by the Board and requested that the Board place Dr. Bellak on Probation with those terms. Ms. Davis also said the State of Wisconsin evaluated the same facts in this case and determined Dr. Bellak is fit to practice medicine. Ms. Davis said Dr. Bellak has no current plans to relocate to Arizona at this time. Dr. Bellak addressed the Board and said he takes full responsibility for his unprofessional conduct but that his recovery is now stable and he has his priorities in the correct order.

Vicki Johansen, Senior Medical Investigator summarized the case for the Board. Ms. Johansen said Dr. Bellak had been charged with several felonies in the state of Wisconsin including, child abuse, battery, victim intimidation, disorderly conduct and bail jumping. Ms. Johansen said Dr. Bellak had also been arrested for driving while under the influence (DUI).

MOTION: Patricia Griffen **moved to accept the Executive Director's Referral to Formal Hearing.**
SECONDED: Patrick N. Connell, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
23.	MD-05-0884A	AMB	HARSHAD S. PATEL, M.D.	22757	Deny Request for Modification of Board Order

Sharon B. Megdal, Ph.D. recused herself from the case.

Chris Banys, Monitoring Office Assistant Manager summarized the case for the Board. Ms. Banys said Dr. Patel is in compliance with his Board Order and is requesting the following restrictions be lifted:
1. Restriction from seeing female patients;
2. Restriction requiring a chaperone for all male patients;
3. Lift restriction to work 30 hours per week to allow a 40 hour work week

Mark Nanney, M.D., Chief Medical Consultant said the Staff Investigational Review Committee (SIRC) recommended the Order be modified with the exception of allowing Dr. Patel to see female patients. Dr. Nanney said the reason for doing so was because of Dr. Patel's past behavior with female patients and the final Board Order had only been in effect for one month at the time Dr. Patel requested modification. Patrick N. Connell, M.D. commented that in the future, the Board may add to the language of their Orders a time period after the issue date that they would be most willing to consider a modification to the Order. The Board members agreed Dr. Patel should remain under the current order for at least one year after the effective date of the Order prior to requesting a modification.

MOTION: Patrick N. Connell, M.D. moved to deny the request for modification of a Board Order.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 7-yay, 0-nay, 0-abstain, 1-recuse, 4-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
24.	MD-05-0782A	AMB	DERYL R. LAMB, M.D.	21010	Accept Consent Agreement for Decree of Censure and Probation for negligent obstetric care in numerous patients resulting in fetal demise in one patient and for poor medical record keeping.
25.	MD-06-0037A	ARIZONA MEDICAL BOARD	DARIUSH GHAFFARI, M.D.	21840	Accept Consent Agreement for Surrender of Active License.

MOTION: Patrick N. Connell, M.D. moved to accept the Consent Agreements for items 24 and 25.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D. and Douglas D. Lee, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 0-recuse, 4-absent
MOTION PASSED.

WEDNESDAY, August 9, 2006

CALL TO ORDER
Robert P. Goldfarb called the meeting to Order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Tim B. Hunter, M.D.

CALL TO PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0511A	AMB	JOAN N. WARNER, M.D.	27858	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize fetal distress and failure to promptly deliver two fetuses.

Joan Warner, M.D. was present with counsel, Mr. Robert J. Milligan.

Robert P. Goldfarb, M.D. said he knows Mr. Milligan professionally, but it would not affect his ability to adjudicate the case.

Ingrid Haas, M.D. Internal Medical Consultant summarized the case for the Board. Dr. Warner's hospital privileges were temporarily suspended based on two obstetrical cases. The first case involved a pregnant patient HD who had fetal distress and Dr. Warner elected a C-section. At the time another C-section was on-going and only one anesthesiologist was available. The C-section occurred some time after it was ordered and HD's infant was delivered with no further complications. Dr. Haas said the second case involved pregnant patient KC who was noted to have variable decelerations each time she pushed. Dr. Warner attempted vacuum delivery three times before delivery occurred. KC's infant died following delivery. Dr. Warner has since undergone additional training and her obstetric privileges have since been reinstated.

Dr. Warner, in her opening statement, said for patient HD, the operating room was not available and neither was the only anesthesiologist. Dr. Warner said HD's infant was initially depressed at birth, but no further complications were noted and the infant was currently thriving. In the second case, patient KC's pushing produced variable decelerations and when she had KC stop pushing it resolved. Dr. Warner said she left KC's bedside, but did not leave the hospital. Dr. Warner said she received delayed communication from the nursing staff regarding critical changes in the fetal status. Dr. Warner said when she later delivered the infant KC was adamantly against a C-Section and, since Dr. Warner felt KC met the criteria for vacuum delivery, she proceeded with such. The infant died.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Petelin said there was a red flag on the fetal heart monitoring, intrauterine resuscitation was not instituted quickly and the Pitocin was continued for patient HD much longer than necessary. Dr. Petelin said he was not comfortable with the approximate three hour delay in performing HD's C-section after Dr. Warner had ordered it. Dr. Petelin found Dr. Warner should have been more forceful and aggressive to deliver the fetus in distress, regardless of what the operating room policy is. Dr. Petelin also noted the infant was delivered with a low Apgar score and the infant subsequently had seizure activity that required seven additional days of hospitalization.

Dr. Petelin noted for the second case involving patient KC Dr. Warner's medical records did not show KC was adamant against undergoing a C-section. Dr. Warner conceded her documentation could be improved in this case. Dr. Petelin also found that, upon delivery, it was noted the infant had an abnormal umbilical cord. Dr. Petelin said, however, the abnormal umbilical cord had no impact on the development of the fetus and the infant's demise was caused by multi-organ failure.

Douglas D. Lee, M.D. said the American College of Obstetrics and Gynecologist (ACOG) Guidelines require a C-Section to be performed within 30 minutes in the case of an emergency Dr. Warner agreed with these guidelines, but noted at the time of delivery she believed the C-section was indicated, but not emergent.

Dr. Warner said in closing she has learned from these experiences and has become a more aggressive advocate in her patient's care and has improved her documentation. Dr. Warner said she in retrospect she wished she would have been more aggressive in facilitating the C-Section more quickly for HD and wished she would have performed a C-section for KC.

Mr. Milligan said Dr. Warner was not given critical information from hospital staff to cause her to realize the case of HD was an emergent situation. Mr. Milligan said the nurse in the case of HD made an error in not instituting resuscitative measures sooner, but this was not related to Dr. Warner's care. Mr. Milligan said, although Dr. Warner would do things differently in retrospect, based on the information she had at time she handled the cases appropriately.

Dr. Haas summarized by stating for KC, leaving a patient with fetal distress is not the best practice. Dr. Haas said for HD, once a C-section was determined to be necessary, it should have been accomplished within a 30-minute window.

Dr. Petelin said the standard of care is to recognize fetal distress and promptly deliver the fetus in the case of distress and that he found Dr. Warner failed to meet this standard in the two cases.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

Dr. Petelin said there was actual harm in both cases. Dr. Petelin said the actual harm in the case of HD was the infant having low Apgar scores, and developing a seizure requiring a prolonged hospital stay. Dr. Petelin said in the case of KC the infant's died. Dr. Petelin said he considered the mitigating factors in this case and acknowledged Dr. Warner's hospital privileges had been reinstated, however, Dr. Petelin found disciplinary action was warranted as both cases showed fetal harm.

MOTION: Paul M. Petelin, Sr., M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize fetal distress and failure to promptly deliver two fetuses.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was not present: Tim B. Hunter, M.D. The following Board Member abstained: William R. Martin, III, M.D.

VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

MOTION: Dona Pardo, Ph.D., R.N. moved to refer the nurse in the case of patient HD to the Arizona State Board of Nursing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0503A	AMB	DUANE G. MARTIN, M.D.	30487	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize signs and symptoms of myocardial origin upon examination and failure to obtain an electrocardiogram depriving the patient of a chance for earlier intervention.

Duane Martin, M.D. was present with counsel Mr. Paul Giancola.

William R. Martin, III, M.D. said he knows Mr. Giancola, but it would not affect his ability to adjudicate the case.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Dr. Huber said this case was the result of a medical malpractice case where Dr. Martin diagnosed patient JM's musculoskeletal problems and did not perform an adequate workup. One week later, JM was hospitalized for myocardial infarction and died. The medical consultant found Dr. Martin fell below the standard of care by failing to perform an electrocardiogram (EKG) for JM on the initial visit.

Dr. Martin said when saw JM initially, he carefully questioned JM concerning cardiac signs, location, radiation, duration of pain and JM denied any chest pain or tightness. Dr. Martin said JM also denied nausea, emesis, sweating shortness of breath or anxiety. Dr. Martin said, in retrospect, he realizes JM had an atypical cardiac presentation and he has since learned from this and now performs EKGs on all patients with cardiac symptoms regardless of his level of suspicion.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller said the medical record did not document that Dr. Martin asked JM thorough questions, but it was documented that JM had three days of shoulder pain not related to exertion. Dr. Mackstaller also noted the medical record recorded a complaint of "chest tightness". Dr. Mackstaller said it was concerning that JM's family history also showed he was at increased risk for a cardiac event and that, although JM's cardiac pain was atypical, an EKG was indicated. Dr. Mackstaller said it was possible JM had both musculoskeletal pain and cardiac problems.

Dr. Martin said he was an Ear Nose and Throat (ENT) specialist by training, but was working for an Urgent Care at the time this case occurred. Dr. Martin said he has now returned to the practice of ENT alone. Dr. Martin said this event has changed the way he practices in that he is more aware that diseases do not always present with typical symptoms.

Mr. Giancola quoted an expert's opinion on this case who found an EKG was not indicated for patient JM based on JM's presentation.

Dr. Mackstaller said Dr. Martin failed to recognize the possibility of cardiac symptoms and he fell below the standard of care by failing to order an EKG.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse,1-absent
MOTION PASSED.

William R. Martin, III, M.D. noted the myocardial event could have occurred prior to JM presenting to Dr. Martin. Dr. Mackstaller agreed, but said that, if that were the case, it further proved why an EKG would have been helpful.

MOTION: Lorraine Mackstaller, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize signs and symptoms of myocardial origin upon examination and failure to obtain an electrocardiogram that deprived the patient of a chance for earlier intervention.
SECONDED: Patrick N. Connell, M.D.

Patrick N. Connell, M.D. noted he believed Dr. Martin was clearly working out of his element when he, an ENT physician, was working in an Urgent Care setting.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D., The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0663A	AMB	PAUL E. WALSHAW, M.D.	24073	Issue an advisory letter for failure to follow up appropriately on an ordered CT Scan and for failure to be aware patient was on anticoagulants.

Paul Walshaw, M.D. was present with counsel Mr. Tom Slutes.

Lorraine Mackstaller, M.D. said she knows Dr. Walshaw, but it would not affect her ability to adjudicate the case. Robert P. Goldfarb, M.D. recused himself from the case.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. This case came to the Board as a result of a medical malpractice settlement alleging Dr. Walshaw failed to hospitalize and treat a patient following diagnosis of cranial hematoma resulting in subsequent death. The Outside Medical Consultant (OMC) found the standard of care was to refer the patient to the emergency room immediately after the radiology finding of hematoma. The OMC found Dr. Walshaw's untimely referral resulted in patient death that may have been prevented otherwise.

Patrick N. Connell, M.D. led the questioning. Dr. Walshaw said the radiologist informed him the patient had a frontal hematoma, but there was not an active bleed. Dr. Walshaw said the radiologist was calm when discussing the findings and did not lead Dr. Walshaw to believe the situation was emergent. Dr. Walshaw said he did not see the head computed tomography (CT) scan on the day he was notified of the results, but said reading the CT was out of his area of expertise and he would not have been able to determine if an active bleed was taking place. Dr. Walshaw also said that if he would have remembered the patient was anti-coagulated he would have had increased concern for active bleeding. Dr. Walshaw said his plan was to call the patient later in the day when her chart was in front of him. He said the chart would have reminded him the patient was on Coumadin and he would have sent her to the Emergency Room.

Lorraine Mackstaller, M.D. noted there was a note in the chart that the patient first complained of headache on Feb 19th and that by March 12th it was noted that vomiting accompanied the headache, and yet Dr. Walshaw did not take a history to determine how often the patient was vomiting and if there were any other symptoms. Douglas D. Lee, M.D. noted that when a patient presents with both a headache and a frontal hematoma bleed the patient should be evaluated emergently.

Dr. Connell said he understood how this scenario could occur. Dr. Connell said Dr. Walshaw knew the radiologist was not concerned about the findings; Dr. Walshaw did not have the patient's records in front of him to remember she was anti-coagulated and had a plan to call the patient later that day when the records were in front of him. Dr. Connell also noted that Dr. Walshaw admitted if he would have remembered the patient was anti-coagulated, he would have acted differently.

MOTION: Patrick N. Connell, M.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.

Paul M. Petelin, Sr., M.D. spoke against the motion stating the patient's coagulation studies were completely out of line and that should have prompted action. William R. Martin, III, M.D. also spoke against the motion due to desire for Board consistency and said that if the patient had been referred to the emergency room or a neurosurgical consultation, the outcome may have been different. Dr. Mackstaller also spoke against the motion stating an abnormal finding deserved attention. Dr. Mackstaller, M.D. said, regardless of a physician's specialty or area of expertise, if a test is ordered the physician who ordered the test must follow up on the results. If the results show a finding out of the physician's area of expertise, the case should be referred to a specialist. Sharon B. Megdal, Ph.D. also spoke against the motion.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D. The following Board members voted against the motion: Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was recused: Robert P. Goldfarb, M.D. The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 4-yay, 6-nay, 0-abstain, 1-recuse,1-absent
MOTION FAILED.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for failure to follow up appropriately on an ordered CT scan and for failure to be aware his patient was on anticoagulants.
SECONDED: Lorraine Mackstaller, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Dona Pardo, Ph.D., R.N. The following Board Member was recused: Robert P. Goldfarb, M.D. The following Board Member was not present: Tim B. Hunter, M.D.
VOTE: 9-yay, 1-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-05-0623A	AMB	ZELALEM YILMA, M.D.	25431	Dismiss

Richard Lewis, M.D. was present and spoke during the call to the public in support of Dr. Yilma. Dr. Lewis said he believed the stress test performed by Dr. Yilma in this case was adequate and was not incomplete as the Board's investigation had suggested.

Zelalem Yilma, M.D. was present with counsel, Mr. Stephen Myers.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. A patient presented with classic symptoms of cardiac disease. Dr. Yilma was consulted for the sole purpose of doing a treadmill stress test. The Outside Medical Consultant (OMC) in this case found the stress test should have been read as "incomplete" as it was terminated early due to the patient's chest pain, left leg pain and fatigue. The OMC found Dr. Yilma's inaccurate assessment of the stress test led to a false negative result provided to both the patient and the treating physician and, as a result, further testing was not done for the diagnosis of coronary artery disease.

Lorraine Mackstaller, M.D. led the questioning. Dr. Yilma said the patient's chest pain was not responsive to nitroglycerin, making it atypical chest pain. Secondly, Dr. Yilma said the patient was in the emergency room with chest pain for 3-4 hours prior to the stress test and monitored on telemetry at that time. Dr. Yilma said the results of the monitoring showed the patient had no ST segment deviation with any of the episodes of chest pain.

Dr. Mackstaller noted the medical record said the stress test was stopped due to the patient's chest pain, left leg pain and fatigue. Dr. Yilma said she presumed the medical record was erroneously marked because she said she was standing next to the patient during the test and the test was not stopped for that reason. Dr. Yilma said all of the records related to the stress test where lost, including her dictated report.

Lorraine Mackstaller, M.D. said it was mitigating that Dr. Yilma was physically present for the stress test and testified under oath that the patient had no chest pain during the stress test and it was not concluded early because of such. William R. Martin, III, M.D. said it would be difficult to consider all of the details in this case because the hospital lost the medical records pertaining to the stress test.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr., M.D. The following Board Member was absent; Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

CALL TO THE PUBLIC – 1:15 p.m.

Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-03-0014A	AMB	ZEV FAINSILBER, M.D.	22634	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and 5 Year Probation to include the use of a female chaperone with all female patients. The chaperone shall be present during all interactions with the patient and document her initials on the patient's chart at the time of the visit. The physician shall obtain continuing therapy regarding boundary issues and psychosocial issues. The physician shall obtain 15 hours CME in medical records to be completed within 6 months. The physician may apply to cease seeing the psychotherapist in two years.

Zev Fainsilber, M.D. was present with counsel Mr. Gordon M. Lewis.

Kathleen Muller, Monitoring Office Manager summarized the care for the Board. Based on Dr. Fainsilber's psychological evaluation, Steven R. Grey, Ed.D recommended Dr. Fainsilber undergo therapy to address behavior which generated complaints for sexual misconduct and also recommended Dr. Fainsilber have a personal chaperone.

Douglas D. Lee, M.D. led the questioning and asked Dr. Fainsilber about his encounter with the patient. Dr. Fainsilber said he never touched the patient when examining her moles on her inner thighs and between her breasts. Dr. Lee noted Dr. Fainsilber had an assistant the first time he went in the room, but when he re-entered the room, after the patient had undressed, Dr. Fainsilber did not take his medical assistant with him.

Dr. Fainsilber said after the patient left the office he discovered she had a history of melanoma and then called the patient and asked her to return that day or the next day if possible. Dr. Lee noted it was odd that Dr. Fainsilber called the patient directly rather than having his staff call the patient. Dr. Lee also found it odd that Dr. Fainsilber did not document the phone call to the patient in the medical record and that it was his testimony he did not tell the patient why she should return for follow up. When Dr. Lee initially questioned Dr. Fainsilber about the patient's allegation that he called and asked her if she was "okay", Dr. Fainsilber denied saying such during the phone call. However, when Dr. Lee mentioned the patient had recorded the phone conversation, Dr. Fainsilber said he could not recall if he did or did not ask the patient if she was "okay".

Dr. Lee questioned Dr. Fainsilber's medical records and noted that it looked as though he added a history of melanoma to the patient's chart at a later date. Dr. Fainsilber admitted he does not document the dates that new issues arise for patients, but rather records it all on the same problem list at the beginning of the chart, without including a date the new information was written. Dr. Lee noted there was no mention in the note of any follow up for melanoma, or of any concern of melanoma by either Dr. Fainsilber or the patient. Dr. Lee found the patient's prior primary care physician as well as a subsequent primary care physician after the patient left Dr. Fainsilber's care both had very complete history and physical examination lists and under family history neither physician mentioned melanoma. Dr. Lee found it unlikely the patient would only mention a concern of melanoma to Dr. Fainsilber. Dr. Fainsilber said he did not know why know why the patient would make sexual misconduct allegations against him.

Dr. Goldfarb found Dr. Fainsilber's practice of going back to the first page of the medical records and crossing out and adding items without dating when the changes occurred was the inappropriate practice of amending medical records.

William R. Martin, III, M.D. said he questioned Dr. Fainsilber's credibility because he said if Dr. Fainsilber was concerned enough about possible melanoma, causing him to call the patient back for an appointment, then he should have been concerned enough to record such information in the medical record. Sharon B. Megdal, Ph.D. noted Dr. Fainsilber did not specialize in skin lesions and found it odd he did not refer the patient to a specialist for his supposed concerns rather than requiring the patient to return to him.

Dona Pardo, Ph.D., R.N. asked Dr. Fainsilber if he had received another complaint for sexual misconduct before this Board previously, as indicated in the complaint letter. Dr. Fainsilber said he had, but the case was dismissed.

Mr. Lewis said Dr. Fainsilber underwent psychosexual evaluation and he continues to have chaperones accompany him for physical examinations for female patients.

Dr. Lee said this case was bothersome and troubling and the examination seemed to boil down to a he said she said situation. However, Dr. Lee said the patient seemed credible in that it was unlikely she would make up such a detailed consistent story with no reason for grudge or ill feelings that would give the motive of revenge toward Dr. Fainsilber. Dr. Lee noted he found Dr. Fainsilber's story had many odd occurrences that did not make sense and his documentation in the patient's medical record was inadequate. Dr. Lee also noted Dr. Fainsilber provided conflicting information to the Board regarding the telephone conversation he had with the patient.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for issuing inaccurate information to the Board.
SECONDED: Patrick N. Connell, M.D.

Dr. Martin spoke against the motion stating it did not appear Dr. Fainsilber's testimony had been forthright and it appeared Dr. Fainsilber was also not forthright during his the psychosexual evaluation as the evaluation was inconclusive. Dr. Martin said he did not believe an Advisory Letter would adequately protect the public.

The Board went into Executive Session 3:59 p.m.
The Board returned to Open Session at 4:15 p.m.

Patrick N. Connell, M.D. withdrew his second to the motion. There was not another seconder, so the motion failed.

Dr. Connell said he did not find Dr. Fainsilber's testimony credible and he believed Dr. Fainsilber fell below the standard of care because he did not have a plan to deal with possible melanoma. Dr. Connell said Dr. Fainsilber failed to appropriately document his concerns and refer the patient to a melanoma to specialist in timely fashion. Dr. Connell also said Dr. Fainsilber failed to create an environment or situation in which the patient could feel she was not being sexual molested, touched or having inappropriate favors requested.

The Board discussed whether or not they should cite Dr. Fainsilber for inadequate medical records. Christine Cassetta, Board Legal Counsel advised the Board that Dr. Fainsilber had been noticed for a violation of A.R.S. §32-1401 (27)(t) and that statute encompassed altering the medical records.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(z) - Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee, for purposes of this subdivision, "Sexual Conduct" includes: (i) Engaging in or soliciting sexual

relationships, whether consensual or nonconsensual; (ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature; (iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.
SECONDED: Patricia R.J. Griffen
VOTE: 9-yay, 1-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand and 5 Year Probation to include the use of a female chaperone with all female patients. The chaperone shall be present during all interactions with the patient and document her initials on the patient's chart at the time of the visit. The physician shall obtain continuing therapy regarding boundary issues and psychosocial issues. The physician shall obtain 15 hours CME in medical records to be completed within 6 months. The physician may apply to cease seeing the psychotherapist in two years.
SECONDED: William R. Martin, III, M.D.

Dr. Martin noted his belief that the action was not within the normal pattern of actions taken by the Board but that this case was weighed with the evidence and the Board has decided collectively that Dr. Fainsilber's testimony is not credible. Dr. Martin said, therefore, the preponderance of the evidence standard was met.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-03-0015A MD-03-0474A	AMB	INNA OGANDZHANOVA, M.D.	28680	Dismiss

Inna Ogandzhanova, M.D. was present with counsel Mr. Jim Kaucher.

Patricia R.J. Griffen recused herself from the case.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. The allegation in this case was that Dr. Ogandzhanova overprescribed radiation dosage for two separate patients. Dr. Sems said both Outside Medical Consultants found there was a deviation from the standard of care due to excessive radiation and in the second case, both potential and actual harm was found.

Dr. Ogandzhanova, in her opening statement, said patient GE did not experience high daily doses of radiation because if she would have, she would have shown toxic levels. Dr. Ogandzhanova said there were films critical in describing this case that were missing as the other treating physician in this case.did not provide those films to the Board. Dr. Ogandzhanova said both patients received appropriate care in these cases.

William R. Martin, III, M.D. led the questioning.

Dr. Martin noted there were two Outside Medical Consultants who are trained radiation oncologists who found she gave an excess of radiation in these cases. Dr. Martin noted Dr. Ogandzhanova prescribed 40 grades of radiation when the textbooks state 35 grade of radiation is dangerous.

Dr. Ogandzhanova explained that while more than 35 grades of radiation to 100% of an organ is dangerous it is within the standard of care to administer more than 35 grades of radiation to a smaller portion of the organ without the same effects. In the case of patient AQ Dr. Ogandzhanova explained that she administered 40 grades of radiation to AQ's liver. Her goal in administering this dosage was to palliate the AQ's pain.

Dr. Martin noted the OMC's reports indicated they were not referring to the entire liver, but that the only time a dose this large can be given is when the patient has a disease that is without treatment and would cause both hepatic failure and death or if the patient has limited life span usually less than three months and the treatment is for palliation of severe pain only.

Mr. Kaucher said part of the dosage of radiation administered to the patients was given by electron radiation and the other part by photon radiation. Mr. Kaucher said photon radiation penetrates more deeply and when administering radiation in this combination a higher dosage of radiation is acceptable.

MOTION: William R. Martin, III, M.D. moved to dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.

Paul M. Petelin, Sr., M.D. spoke in favor of dismissal of the cases stating there was an internal conflict between Dr. Ogandzhanova her former partner, who participated in the patients' treatments and who also filed the complaint against Dr. Ogandzhanova. Robert P. Goldfarb, M.D. also spoke in favor of dismissal stating the other physician did not provide all of the medical records to the Board so the case could be thoroughly reviewed.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III,

M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Tim B. Hunter, M.D., The following Board Member was recused: Patricia R.J. Griffen
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-0187A	AMB	T.S. SOUNDARARAJAN, M.D.	15670	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for an action taken in another state for conduct that is unprofessional conduct in Arizona.

T.S. Soundararajan, M.D. (Dr. Rajan) was present without counsel.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Dr. Rajan reported to the Arizona Medical Board that he was placed on a five year Probation by the California Medical Board and was required to complete a Physician Assessment and Clinical Evaluation (PACE) program. The disciplinary action arose out of issues pertaining to a personnel matter with the California Department of Corrections and State Personnel Board of California. Dr. Huber said Dr. Rajan has an Arizona license, but has not practiced in Arizona since 1974. Dr. Rajan has since completed his California disciplinary requirements successfully.

Sharon B. Megdal, Ph.D. led the questioning. Dr. Megdal noted Dr. Rajan had satisfied all the terms of his California probation with the only remaining restriction being that he cannot supervise physician assistants. Dr. Megdal noted Dr. Rajan was offered a Consent Agreement by Staff that mirrored the terms of the California Board Order, but he refused the Consent Agreement. Dr. Megdal also noted that the California Medical Board typically imposed a restriction from supervising physician assistants when issuing discipline and confirmed that the action taken by the California Medical Board had nothing to do with his supervision of physician assistants.

Dr. Rajan said, since the time of the California Board disciplinary action he has taken continuing medical education courses and has received extensive education. Dr. Rajan said in light of his subsequent education he can see how his practice would change if he were confronted with similar circumstances in the future.

Dr. Megdal said the quality of care issues in this case would entail changes made to a patient's seizure medication, without documenting a reason to do so, and the patient's subsequent withdraw of the seizure medication.

MOTION: Sharon B. Megdal, Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)§32-1401(27)(o) - Action that is taken against a doctor of medicine by another licensing or regulatory jurisdiction due to that doctor's mental or physical inability to engage safely in the practice of medicine, the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph. The action taken may include refusing, denying, revoking or suspending a license by that jurisdiction or a surrendering of a license to that jurisdiction, otherwise limiting, restricting or monitoring a licensee by that jurisdiction or placing a licensee on probation by that jurisdiction and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Becky Jordan
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

MOTION: Becky Jordan moved to Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for an action taken in another state for conduct that is unprofessional conduct in Arizona.
SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr., M.D. The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0460A	AMB	DANIEL J. MARTINIE, M.D.	29155	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for an inappropriate sexual relationship with a patient and for an Article 15 action taken by the Federal Government.

Daniel Martinie, M.D. was present without counsel.

Victoria Kamm, Senior Medical Investigator summarized the case for the Board. The Arizona Medical Board received notice of a Department of Defense - United States Air Force had taken an Article 15 action against Dr. Martinie for engaging in a sexual relationship with a patient. Dr. Martinie did not deny the relationship. Dr. Martinie also prescribed a narcotic prescription to the patient after he had discharged the patient from his care.

Becky Jordan led the questioning. Dr. Martinie said he was in the role of the patient's primary care physician initially, but he eventually transferred her care to another physician. Dr. Martinie said he has taken 20 hours of continuing medical education in ethics as a result of the action against him by the Air Force. Dr. Martinie said his relationship with the patient ended around June of 2003 and on July 18, 2003 the

patient's husband requested Dr. Martinie prescribe a narcotic medication for his wife as they were traveling. Ms. Jordan noted Dr. Martine had been absolved of any wrong doing in the case of issuing the prescription as Dr. Martinie's supervisor said the prescription was a chronic medication the patient took and Dr. Martinie was the only physician available to provide the medication to the patient at the time she was traveling.

Dr. Martinie said he did not deny the allegations in this case and regrets the situation. Dr. Martinie said he will not be in the same situation again.

MOTION: Becky Jordan moved to moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(p) - Sanctions imposed by an agency of the federal government, including restricting, suspending, limiting or removing a person from the practice of medicine or restricting that person's ability to obtain financial remuneration, A.R.S. §32-1401 (27)(z) - Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee, for purposes of this subdivision, "Sexual Conduct" includes:
(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.
(ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature.
(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

Ms. Jordan found Dr. Martinie did not comply with statutory regulation because he did not terminate the physician/patient relationship with the female prior to six months before engaging in a sexual relationship. Ms. Jordan found the inappropriate prescribing issue was mitigated in this case.
MOTION: Becky Jordan Issue Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for an inappropriate sexual relationship with a patient.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D., The following Board Member was not present: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ALJ RECOMMENDED DECISION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-L300A	AMB	CHARLES M. BAZZELL, M.D.	N/A	Accept ALJ Recommended Findings of Fact and Conclusions of Law as amended. Grant an Arizona License.

Charles Bazzell, M.D. was present with counsel Mr. Paul Giancola.

Robert P. Goldfarb, M.D. recused himself from the case.

Mr. Giancola said Dr. Bazzell sought legal counsel prior to completing the Arizona Board's license application and filled out the application based on the advice of his attorney. Mr. Giancola also said the Minnesota Board reviewed this matter and dismissed the case. Mr. Giancola said Dr. Bazzell has a clean criminal record. The Administrative Law Judge (ALJ) did not find Dr. Bazzell in the wrong for answering the Arizona Medical Board license application incorrectly, but rather found he was not eligible for an Arizona license because he committed a felony. However, Mr. Giancola said the ALJ is incorrect because Dr. Bazzell did not commit a felony. Mr. Giancola said Dr. Bazzell has currently re-applied for an Arizona state license.

Dean Brekke, Assistant Attorney General requested the Board modify paragraphs 2, 10, and 20 in the ALJ's recommended Order to reflect the year "2004". Mr. Brekke said this case could be argued both ways. Mr. Brekke said it could be upheld that Dr. Bazzell answered his Arizona Medical Board application question incorrectly when he did not disclose the Minnesota Board's investigation of him, and it could also be argued that he took wrong legal advice from an attorney who advised him he was not required to disclose the Minnesota Board's investigation. Christine Cassetta, Board Legal Counsel said the ALJ made the finding to deny the license based on Dr. Bazzell's prior felony.

The Board went into Executive Session 6:56 p.m.
The Board returned to Open Session at 7:02 p.m.

MOTION: Patrick N. Connell, M.D. moved to accept the ALJ's Findings of Fact with the noted amendments.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to accept the ALJ's Conclusions of Law.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

Sharon B. Megdal, Ph.D. noted that, even in the face of criminal conduct, the issues in this case did not involve quality of care or addiction and his professional record showed he was a fine physician. Dr. Megdal noted Dr. Bazzell had a position waiting for him with the largest anesthesiology group in Tucson where he would have much oversight.

MOTION: Sharon B. Megdal, Ph.D. moved to grant the Arizona license.
SECONDED: Lorraine Mackstaller, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was recused: Robert P. Goldfarb, M.D., The following Board member was absent: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0256A	J.L.	H. LEE MITCHELL , M.D.	30004	Adopt ALJ Recommended Findings of Fact and Conclusions of Law and Order for Revocation of active license.

Anne Froedge, AAG summarized the case for the Board. She informed the Board the Administrative Law Judge (ALJ) recommended Revocation of Dr. Mitchell's license. Ms. Froedge recommended the Board accept the ALJ's decision.

MOTION: Becky Jordan moved to accept the ALJ's recommended Findings of Fact.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to accept the ALJ's recommended Conclusions of Law.
SECONDED: William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. to uphold the summary suspension and accept the ALJ's recommended Order for Revocation of active license.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D.
The following Board Members were not present: Tim B. Hunter, M.D. and Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-02-S010A MD-04-0675A MD-05-0897A MD-05-1022A	AMB	WAHID A. IBRAHIM, M.D.	30413	Adopt the ALJ recommended Findings of Fact, Conclusions of Law and Order for Revocation of an active license.

Anne Froedge, Assistant Attorney General summarized the case for the Board and requested the accept the ALJ's recommended Order.

MOTION: Paul M. Petelin, Sr., M.D. moved to adopt the ALJ's recommended Findings of Fact, Conclusions of Law.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved to adopt the ALJ's recommended Order for Revocation of an active license.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D.
The following Board Members were not present: Tim B. Hunter, M.D. and Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

OTHER BUSINESS

1.	Mary Rimsza, M.D. – Discuss Arizona Physician Workforce Study

Timothy Miller, J.D., Executive Director said Mary Rimsza, M.D. thanks the Board for their help with collecting demographic information from physicians on the license renewal forms and asks for the Boards continued assistance in this area.

THURSDAY, August 10, 2006

CALL TO ORDER
Robert P. Goldfarb, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL
Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Members were not present: Tim B. Hunter, M.D., William R. Martin, III, M.D.

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-04-0850A	AMB	JAMIE MCREYNOLDS, M.D.	15120	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to adequately care for a patient with critical carotid artery stenosis. One year Probation with 20 hours CME in cerebrovascular disease. The probation will expire upon completion of the CME.

Jamie McReynolds, M.D. was present without counsel. Paul M. Petelin, Sr., M.D. recused himself from the case.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. This case came to the Board's attention as a result of a medical malpractice case alleging Dr. McReynolds did not share with the patient the results of a carotid Doppler study showing he had a 99% stenosis of the right internal carotid artery. The Outside Medical Consultant found that more careful follow-up may not have changed the outcome for the patient, but Dr. McReynolds fell below the standard of care by not informing the patient of the test results.

Robert P. Goldfarb, M.D. led the questioning. Dr. McReynolds said when the incident occurred the nurse practitioner did not give her the opportunity that day to intervene in the patient's care. Dr. Goldfarb noted when Dr. McReynolds did see the carotid artery result, the only action she took was to write "needs vascular surgeon?" Dr. McReynolds admitted the proper action with a 99% occlusion of a carotid artery would be to contact the patient immediately and having the patient go to the nearest emergency room.

Dr. Goldfarb noted a phone note for Dr. McReynolds reported the patient could not dress himself. Dr. Goldfarb said, this was a significant change in status. Dr. McReynolds testified that, although the ultrasound result occurred two weeks before the phone message, she was notified of both on the same day and this was a failure of the office system where she was employed. Dr. Goldfarb noted the test result and phone message should have alerted Dr. McReynolds that something significant had occurred with the patient. Dr. Goldfarb noted Dr. McReynolds did not take appropriate action at the time by leaving a voice message that someone would call the patient to see when he could get into the office.

Dr. Goldfarb also noted Dr. McReynolds failed to adequately care for the patient by not performing a more thorough work up on the last visit for which she saw the patient.

Dr. McReynolds said she took responsibility for the events in this case. Dr. McReynolds said, although the system she worked in had many flaws, she had responsibility for changing that system and ultimately did through various meetings and procedure changes. Dr. McReynolds said, additionally, she has since left practicing medicine and currently works in administrative medicine to focus on quality of care issues that physicians face.

Dr. Goldfarb said, although physicians are products of the system where they work, there was unprofessional conduct in this case in Dr. McReynolds' failure to adequately care for a patient with critical carotid stenosis. Dr. Goldfarb found there was actual harm in that the patient suffered a severe cerebral vascular accident resulting in stroke.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Ram R. Krishna, M.D.

Dr. Goldfarb noted an aggravating factor of Dr. McReynolds' prior Advisory Letter for failure to promptly report findings to patient and failure to maintain adequate records.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to adequately care for a patient with critical carotid artery stenosis. One year Probation with 20 hours CME in cerebrovascular disease. The probation will expire upon completion of the CME.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N.
The following Board Members were absent: Tim B. Hunter, M.D., William R. Martin, III, M.D., The following Board Member was recused: Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent

MOTION PASSED.

MOTION: Dona Pardo, Ph.D., R.N. moved to refer the nurse practitioner in this case to the Arizona State Board of Nursing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 1-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-05-0785A	AMB	CARLOS A. CARRION, M.D.	5752	Issue an Advisory Letter for operating on the wrong level for a cervical fusion.

Carlos Carrion, M.D. was present without counsel. William R. Martin, III, M.D. recused himself from the case. Patrick N. Connell, M.D. and Paul M. Petelin, Sr., M.D. said they knew Dr. Carrion, but it would not affect their ability to adjudicate the case.

Gerald Moczynski, M.D., Medical Consultant summarized the care for the Board. A medical malpractice settlement was made on behalf of Dr. Carrion for performing a wrong level surgery on a patient's spinal column. Dr. Moczynski said it was mitigating that Dr. Carrion notified the patient of his error and was also forthright with the Board concerning his mistake. Dr. Moczynski said this forthrightness on Dr. Carrion's part made this case different from other wrong level surgery cases the Board has heard. Dr. Moczynski said the patient underwent a second surgery with Dr. Carrion and the patient's symptoms resolved as a result of the second surgery.

Ram R. Krishna, M.D. led the questioning. Dr. Carrion said that at the time of the first surgery, the x-rays technician taking the films for the patient was inexperienced and took two hours to complete imaging that usually takes 15 minutes. Dr. Carrion said he was frustrated the process was taking too long and subsequently did not wait for the radiologist to provide an official report prior to performing the procedure. Dr. Carrion admitted he changed his practice after this case occurred to always obtain the reading from the radiologist before proceeding. Dr. Carrion admitted he was overconfident in this case and admitted his error immediately to the patient upon his discovery of the wrong level surgery.

The Board reviewed the x-rays in this case and noted that, although the screw/marker was in the correct location prior to surgery, the surgery was performed at the wrong level. Dr. Krishna said he found Dr. Carrion to be a competent physician; however a technical error was made in that the surgery was not performed at the same level as the marker. Dr. Krishna also noted Dr. Carrion received an Advisory Letter in 1995 for a technical error, but it was unclear exactly what that error involved.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patricia R.J. Griffen
VOTE: 9-yay, 1-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

Dr. Krishna found it mitigating that there were no significant side effects or damage to the patient due to the wrong level surgery. He also found it mitigating that Dr. Carrion was forthright with the patient and to the Board and is no longer practicing medicine.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter Issue an advisory letter for operating on the wrong level for a cervical fusion.
SECONDED: Paul M. Petelin, Sr., M.D.

Dona Pardo, Ph.D., R.N. spoke against the motion despite the mitigating circumstances stating a desire for consistency in the Board's actions relating to wrong site surgery. Dr. Pardo said there was harm in that an unnecessary surgery was performed on the patient and a second surgery was required to achieve the correct result. Sharon B. Megdal, Ph.D. stated she was in agreement with Dr. Pardo's comments.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N., The following Board Member abstained: Robert P. Goldfarb, M.D., The following Board Member was recused: William R. Martin, III, M.D., The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 7-yay, 2-nay, 1-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-05-0390A	R.T.	JOHN N. GLOVER, M.D.	8971	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to pursue the etiology an abnormal chest x-ray and worsening clinical picture.

John Glover, M.D. was present with counsel Mr. Stephen Booth.

Complainant RT was present and spoke during the call to the public. RT said her father (EA) was the patient in this case and he did not decline the Computed Tomography (CT) Scan or biopsy as Dr. Glover alleged. RT also said Dr. Glover was informed of the patient's increasing symptoms such as the time her father collapsed after going up one flight of stairs. However, RT said Dr. Glover did not document that in his medical record. RT also said Dr. Glover found her father's significant weight loss to be acceptable, when it should have caused concern and been addressed. RT said Dr. Glover claimed her father did not have Valley Fever when he saw him, however, many symptoms pointed to that

finding and when her father subsequently sought care of other physicians the Valley Fever was so advanced that the right lung was necrotic and other physicians were shocked earlier intervention was not taken for the course of the illness.

Kelly Sems, M.D., Medical Consultant summarized the case for the Board. It was alleged Dr. Glover failed to diagnose and treat a patient leading to unnecessary death. Dr. Sems said, despite the patient's decline for two years, there was no aggressive workup by Dr. Glover. Although it was unknown whether earlier intervention would have changed the patient's course, Dr. Glover did have the responsibility to pursue the cause of the patient's symptoms.

William R. Martin, III, M.D. led the questioning. Dr. Martin said when EA first presented he had no evidence of dyspnea, but later had evidence of dyspnea. Dr. Martin also stated EA went on to have "weakness", developed a productive cough and the patient's Oxygen saturation levels were worse than they've ever been in Dr. Glover's office. Additionally EA had persistent weight loss and the radiologist noted a worsening picture. Dr. Glover said he did not consider these findings concerning because EA did not require an oxygen supplement. Dr. Martin noted Dr. Glover should have taken active intervention in light of the findings and that he failed by telling EA that if he had worsening symptoms he should return in three months for follow up. Dr. Martin noted EA returned in 8 months for follow up.

Dr. Glover said he recommended CT scan of chest or biopsy, but EA declined. Dr. Glover said the patient lacked signs of Valley Fever and so he had no indication to check for that. Dr. Glover said EA was in no worse shape on his last appointment/visit with him. Dr. Glover said EA's 27 pound weight loss was not significant because there are studies that show people lose weight as they age. Dr. Glover said he believed EA developed Valley Fever after leaving his care.

Lorraine Mackstaller, M.D. noted EA had symptoms of Valley Fever such as persistent cough and weight loss that could have been a manifestation of anorexia, which are both signs of Valley Fever. Dr. Mackstaller found that with the prevalence of Valley Fever in Arizona, it should have been on his list of a differential diagnosis workup. Dr. Mackstaller found that with the patient's three years of recurrent symptoms, weight reduction, fatigue and worsening x-ray, a simple blood test may have been beneficial in determining the diagnosis.

Paul M. Petelin, Sr., M.D. noted Dr. Glover recorded in his medical records that an equally valid approach to a CT scan was to observe and follow. Dr. Petelin noted there was no record that EA refused the CT scan, but rather that the CT scan was something Dr. Glover was contemplating and most likely did not impress the need for such to the patient. Dr. Petelin said it appeared Dr. Glover had tunnel vision in this patient's care and he justified his failure to do anything because EA did not require oxygen supplementation. Dr. Petelin said it appeared Dr. Glover stopped pursuing a differential diagnosis for the patient.

Dr. Sems said she found the deviation in this case was that Dr. Glover did not recognize EA was digressing in health during the entire time Dr. Glover cared for him. Dr. Sems said she did not believe the deviation was necessarily that he did not diagnose Valley Fever, but that there was a lack of work up to pursue EA's digression.

Dr. Martin said he found Dr. Glover committed unprofessional conduct in this case. The standard of care is to explain a reasonable diagnosis and this was lacking. Dr. Martin said he found, based on the physician's own records, the testimony from patient's family, and the data presented to the Board, that EA's presentation was worsening and minimal action was taken for work-up. Dr. Martin said he found insufficient workup most likely contributed secondarily to EA's subsequent death from Valley Fever.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Becky Jordan
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

Dr. Martin said Dr. Glover had a clean record with the Board and his testimony before the Board in this case demonstrated he was knowledgeable and up to date on the medical literature. Dr. Martin found it mitigating that EA failed to return for 8 months in follow up and that if he would have returned sooner it may have helped push Dr. Glover to do more intervention. Dr. Martin noted it appeared from the medical records that the CT scan was not refused, but rather was only contemplated as an option by Dr. Glover. Dr. Martin did find patient harm in this case. Dr. Martin said it was not clear when EA developed Valley Fever, and therefore he did not want to specifically link that lack of diagnosis to Dr. Glover.

MOTION: William R. Martin, III, M.D. Draft Finding of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to pursue the etiology of an abnormal chest x-ray and worsening clinical picture.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following board members were absent: Tim B. Hunter, M.D., Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain, 0-recuse, 2-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-04-0776A	AMB	DOUGLAS G. LOWELL, M.D.	19871	Advisory Letter for failure to perform an adequate pre-operative work-up prior to performing a thoracotomy.

Douglas Lowell, M.D. was present with counsel Mr. Dan Cavett. Robert P. Goldfarb, M.D. said he knew Dr. Lowell and Mr. Cavett, but it would not affect his ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The patient presented with an upper thorax and neck mass. It was alleged Dr. Lowell failed to perform a pre-operative thyroid scan of the patient's neck and upper CT prior to the performance of a right thoracotomy. The Outside Medical Consultant found Dr. Lowell deviated from the standard of care by taking the patient to the operating room without performing a complete workup.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Petelin noted there was no documentation of a thyroid examination when the patient first presented to Dr. Lowell, although the referring physician had concerns regarding his thyroid. Dr. Petelin noted Dr. Lowell said he did not perform a thyroid scan because the patient had a CT scan prior to presenting to him and it is advised to wait 5-6 weeks after a CT scan before performing an additional scan such as the thyroid scan. Dr. Lowell said the mass was atypical and the patient had normal thyroid exam. Dr. Lowell said that during the surgery he was surprised to find the patient's mass to be in the retro tracheal area and to be in the superior not the posterior mediastinum. Dr. Lowell said there were no general surgeons available to help him at that point in the procedure and since he was not a neck surgeon, he could not finish the procedure.

The Board viewed the CT scan for this case at this point during the meeting. Dr. Petelin noted the CT scan was of the chest and not of the neck although the lower neck happened to be included in the imaging. Dr. Petelin questioned if the film was sufficient to show the entire mass and thyroid, but because no further imaging was taken, the question was not answered.

Dr. Lowell said he believed he practiced within the standard of care in this case and believed he had the correct test available at the time for treating the patient.

Mr. Cavett said the issue in this case was whether or not a CT scan of the neck should have been performed for the patient. Mr. Cavett said an image was obtained of the thyroid region and an additional image would not have revealed anything further.

Dr. Petelin said the patient did require a second surgery due to Dr. Lowell's inadequate pre-operative work up and the patient suffered harm by having to undergo an unnecessary surgery. Dr. Petelin said he acknowledged this case differed from a wrong side surgery, however the consequences to the patient were not much different as the patient still had to undergo an unnecessary incision and recovery.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for failure to perform an adequate pre-operative work up prior to performing a thoracotomy.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Patrick N. Connell, M.D., The following Board Members abstained: William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. The following Board Member was absent; Tim B. Hunter, M.D.
VOTE: 7-yay, 1-nay, 3-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
5.	MD-05-0815A	AMB	DAVID C. DEAVER, M.D.	12068	Advisory Letter for incomplete evaluation of a head injury to patient prior to discharge.

David Deaver, M.D. was present with counsel Mr. Peter Fisher. Paul M. Petelin, Sr., M.D. recused himself from the case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. A patient presented to Dr. Deaver after being involved in a motor vehicle accident in which she was ejected 20 feet from the vehicle that was traveling at highway speeds. There was a medical malpractice settlement pertaining to the allegation that he failed to order a cranial computed tomography (CT) scan and diagnose a subacute subdural hematoma for the patient. Dr. Wolf said the standard of care for a patient presenting after a traumatic experience that included a loss of consciousness, battle sign, raccoon sign, and combative behavior is to obtain an immediate CT scan of the head.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb noted the signs the patient presented with to Dr. Deaver indicated the need for a CT scan. Dr. Goldfarb said specifically, the Battle's sign behind the patient's ear was an indication of basilar skull fracture. Dr. Goldfarb also noted Dr. Deaver performed a neurological exam before the patient was discharged and discovered the patient had a headache. Dr. Goldfarb said the duration of the patient's headache was about three to four days and, in conjunction with the Battle's sign, should have alerted Dr. Deaver to a more serious issue. Dr. Goldfarb found Dr. Deaver should have also considered the possibility of the patient subsequently developing a subacute hematoma. Dr. Goldfarb concluded Dr. Deaver discharged the patient too early and without an appropriate work up. Dr. Deaver said, in retrospect, he realizes he should have performed a CT scan or a magnetic resonance imaging (MRI) scan. Dr. Deaver said he has since changed his approach and now manages these types of symptoms differently so that a similar situation will occur again in the future.

Lorraine Mackstaller, M.D. noted the patient's agitation should have alerted Dr. Deaver to further assess the severity of the patient's injury. Dr. Deaver said, in retrospect he recognizes this was a red flag, but at the time did not take it as seriously because, when the patient was combative with the hospital staff, the patient's parents informed him that combative behavior was usual for their daughter, who had a history of drug abuse.

Dr. Deaver said he has learned from this experience and has changed his practice as a result of such. Dr. Deaver said since this incident occurred he has facilitated speakers to speak with hospital staff about neurosurgery and the need to evaluate people appropriately.

Dr. Goldfarb noted Dr. Deaver was forthright with the Board, has received ample continuing medical education in this area and now knows how to respond if a similar situation occurs in the future. Dr. Goldfarb said the only deviation in this case was that he released the patient from the hospital without appropriate work up. Dr. Goldfarb said he did not believe Dr. Deaver's treatment caused additional harm to the patient. Dr. Goldfarb said the standard of care in this situation was to order a CT scan as subdural hematomas can cause the patient to appear fine, but then an hour later become unconscious. Dr. Goldfarb, however, noted there was no unprofessional conduct in this case and found it did not rise to the level of a disciplinary action.

MOTION: Robert P. Goldfarb, M.D. move to issue an Advisory Letter for incomplete evaluation of a head injury to a patient prior to discharge.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. The following Board Member was recused: Paul M. Petelin, Sr., M.D., The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 8-yay, 2-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
6.	MD-05-0770A	AMB	RICHARD C. ROTHMAN, M.D.	29754	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to verify the correct data was entered into the laser prior to an ophthalmologic procedure and for failure to adequately supervise a technician, therefore performing the incorrect surgery.

Richard Rothman, M.D. was present with counsel Mr. Kraig Marton.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. The technician working with Dr. Rothman programmed the incorrect data in the Laser machine that was used for a patient's eye surgery. Dr. Rothman verbally checked the settings with the technician prior to surgery, but a miscommunication resulted in a negative number being given that should have been a positive number/figure and therefore an accurate verification was not made. As a result, an incorrect surgery was performed and the patient filed a lawsuit against Dr. Rothman. This matter was dismissed by the Florida Medical Board.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted the operative report is printed automatically by the laser machine and clearly showed the wrong number was entered into the machine. Dr. Rothman said there was a system in place where he verbally confirmed the numbers with the technician prior to surgery, but that he has since changed his practice so that he views the numbers rather than verbally confirming them prior to surgery. Dr. Rothman said a minus (negative) sign was entered into the machine instead of plus (positive) sign. Dr. Rothman said the verbal confirmation with the technician failed in this case although it was the safety protocol he had been taught in training and had used for thousands of cases with excellent results. Dr. Rothman said as a result of the surgery in which the incorrect information was entered the patient's his eyesight was identical to what it was prior to the procedure.

Dr. Connell said the standard of care in a photorefractive keratectomy procedure as this required the surgeon to physically check the settings on the machine prior to the procedure. Dr. Connell acknowledged Dr. Rothman has since changed his practice to visually check the settings. However, Dr. Connell found the physician is ultimately responsible for the outcome of the surgery. Dr. Connell found there was actual harm in this case as the patient did not achieve the desired correction for the elected procedure.

MOTION: Patrick N. Connell, M.D. moved to find moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ii) - Lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician.
SECONDED: Ram R. Krishna, M.D.

Dona Pardo, Ph.D., R.N. spoke against the motion stating a finding of unprofessional conduct was excessive. Paul M. Petelin, Sr., M.D. spoke against the motion stating he did not believe Dr. Rothman was at fault in this case. William R. Martin, III, M.D. spoke in favor of the motion stating the physician should be held accountable.

Christine Cassetta, Board Legal Counsel noted the Board discussed this issue at the last Board meeting and had agreed on a list of things the physician is responsible for before, during and after surgery and that, based on the Board's prior discussion the physician in this case was responsible for not completely verifying the information prior to surgery.

Dr. Connell said it does not put undue burden on the physician to visually verify the data is correct prior to surgery. Dr. Petelin spoke against the motion stating, no matter how improved a system becomes, it will never be fool proof and the same event could occur again in the future, regardless of the caution taken.

VOTE: 6-yay, 5-nay, 0-abstain, 0-recuse, 1-absent

MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to verify the correct data was entered into the laser prior to an ophthalmologic procedure and for failure to adequately supervise a technician, and therefore performing the incorrect surgery.

Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. and Dr. Petelin spoke against disciplinary action.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Tim B. Hunter, M.D.
VOTE: 6-yay, 5-nay, 0-abstain, 0-recuse, 1-absent
MOTION PASSED.

The meeting was adjourned at 6:31 p.m.

Timothy C. Miller, J.D., Executive Director